

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 46

Primary Registration District No. 5152

Registrar's No. 40034423

STATE FILE NUMBER

SEFILED 21 64

PLACE OF DEATH

a. COUNTY

Caldwell

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN Franklin

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Ray

c. CITY OR TOWN

Reinal

Inside Limits

Yes ☐ No ☒

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

San Can on Hwy 13

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)

4 mi S. of Polo

Reside on Farm

Yes ☒ No ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Samuel P. Tiegarden

4. DATE OF DEATH

Month

Day

Year

Sept. 11 - 1964

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

8-26-1892

9. AGE (last birthday)

72

IF UNDER 1 YEAR

Months

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Ray Co Mo.

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

Mose Tiegarden

13b. MOTHER'S MAIDEN NAME

Julia Albright

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

99

17. INFORMANT

Samuel Tiegarden

Address

Lawson Mo

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Coronary Arteriosclerosis

many years

DUE TO (c)

Generalized arteriosclerosis

many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Chronic Bronchial Asthma

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from June 1955 to Sept 11, 1964 and last saw him alive on Sept. 2, 1964

Death occurred at 10 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

E. Goldberg M.D.

22b. ADDRESS

Braymer, Mo.

22c. DATE SIGNED

9/19/64

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

9-14-1964

23c. NAME OF CEMETERY OR CREMATORY

Tiegarden Cemetery

23d. LOCATION (City, town, or county)

3 mi S.W. of Polo Mo

24. FUNERAL DIRECTOR

ADDRESS

Alspaugh & Cowley Polo Mo.

25. DATE RECD. BY LOCAL REG.

Sept 18-64

26. REGISTRAR'S SIGNATURE

Shades Jones

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**STATEMENT BY LICENSED EMBALMER**

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

Licensed Embalmer No \_\_\_\_\_

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.